June 6, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: **MDR Tracking #: M2-03-0938-01**

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___ external review panel. The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a female who sustained a work related injury on ___. The patient reported that while at work she was bussing dirty dishes from an empty dinner table when she slipped and fell in a puddle of water. The patient underwent X-Rays that were reported to be negative. The patient has been treated with oral pain medications, pain management, lumbar laminectomy and discectomy in March of 2002, post surgical active therapy, post surgical injections and completion of a work hardening program. The diagnoses for this patient include post lumbar laminectomy syndrome, bilateral lumbar facet syndrome, lumbar discogenic pain, and myofascial pain.

Requested Services

Pain Management Program.

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a female who sustained a work related injury to her back on ___. The ___ chiropractor reviewer also noted that the diagnoses for this patient included post lumbar laminectomy syndrome, bilateral lumbar facet syndrome, lumbar discogenic pain and myofascial pain. The ___ chiropractor reviewer further noted that

this patient was treated with oral pain medications, pain management, lumbar laminectomy and discectomy, post surgical active therapy, post surgical injections and completion of a work hardening program. The ___ chiropractor reviewer indicated that the patient has chronic pain that has not responded to any form of care to date. The ___ chiropractor reviewer noted that the patient has been through 40 sessions of chronic pain management. The ___ chiropractor reviewer explained that 40 sessions of chronic pain management is a sufficient amount of care for someone to learn all of the coping techniques necessary. The ___ chiropractor reviewer explained that research has shown that if the chronic pain persists past 1 ½ years that there is very little therapy that will change that learned pattern. Therefore, the ___ chiropractor consultant concluded that the requested pain management program is not medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 6th day of June 2003.